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Aberdeen venereal diseases clinic, 1960-1969
Perspective on female attenders

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In Aberdeen, as elsewhere, the number of patients attending the venereal diseases clinic has increased in recent years, corresponding with the increase in illegitimacy. Many epidemiological studies in the field of human reproduction have been undertaken in Aberdeen because of special features in the area and the facilities available. The population is well-defined and fairly stable, there is good integration of the work of hospital specialists, family doctors, and the staff of the Public Health Department of the Local Authority, and records are centralized. This paper deals with the work of the Aberdeen V.D. Clinic in the years 1960–1969.

This clinic is situated in the outpatients department of the general hospital. The team who staff the clinic, a venereologist, part-time general practitioner, two male technicians, and a secretary, have worked together for over 11 years, assisted by nursing staff and a part-time health visitor. This stability has led to the establishment of an efficient record system and to the maintenance of standardized medical records with certain demographic and social data collected routinely.

ABERDEEN V.D. CLINIC RECORDS

The records at the clinic have been carefully completed and cross-referenced for previous attendances and also for sexual partners who may have been a source of infection. Numbers are used throughout the medical records to identify patients and their area of residence is coded, so that anonymity is preserved.

A separate number is allocated and a separate medical record prepared for each 'case' defined as an attendance either for diagnosis (*i.e.* each *new* consultation) or for concurrent disease. For example, there will be two separate, but cross-referenced, medical records for a woman suffering from both gonorrhoea and concurrent trichomonal vaginitis.

The detailed analysis of the Aberdeen V.D. Clinic records for 1960–69, reported here, refers to female attenders, and the findings can be related to trends in total 'cases', illegitimacy, and contraceptive measures. Annual trends in respect of incidence, residence, referral, diagnosis, and age will be considered, followed by a description of attenders of childbearing age only.

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OVERALL TRENDS AND BACKGROUND

Since the clinic opened in 1918 the annual number of 'cases' has been remarkably stable, except for the outstanding war-time peak in 1941–46 inclusive (Fig. 1). Thereafter, the number fell in a few years to the pre-war level and in 1960 it was the lowest recorded since 1923. Subsequently, there was a slight upward trend with a steep rise in 1968 to the highest level reached since 1946.

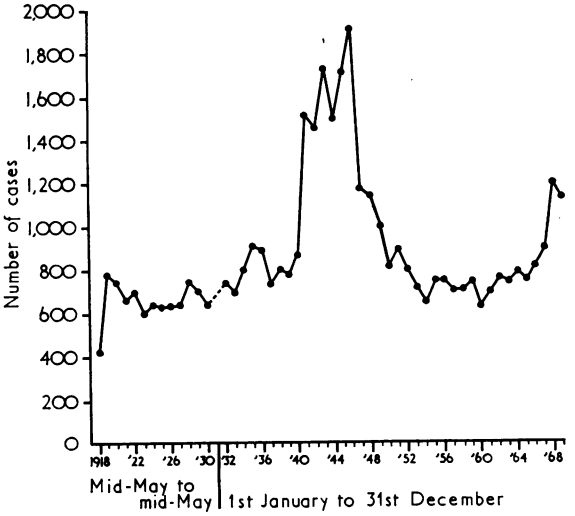

FIG. 1 *Total number of 'cases', male and female, 1918 to 1969*

About one-quarter of 'cases' in the 1960s related to females, the proportion in each year ranging from 20 per cent. in 1961 to 31 per cent. in 1968. Over the decade, female 'cases' showed a proportionately greater increase than male 'cases'; there was 2·5

times more female 'cases' in 1969 than in 1960, the corresponding figure for males being 1·75 times.

The greater demands made on the services of the V.D. clinic reflect the risks associated with the more liberal sexual behaviour found in an increasingly mobile society. A parallel feature was the rise in the percentage of illegitimate births in Aberdeen from 4·7 in 1960 to 8·7 in 1969. An increasing proportion of illegitimate pregnancies was terminated during the decade and, without such action, about 14 per cent. of Aberdeen births in 1969 might have been illegitimate.

The majority of illegitimate pregnancies occur in unmarried women who, in earlier years, came from the lower social classes and were engaged in the more unattractive menial jobs (Thompson, 1956). In recent years, however, students and workers in professional, clerical, and distributive occupations have been increasingly implicated (Gill, 1970), particularly in requests for termination of pregnancy (Aitken-Swan, 1971). These more highly educated women have also contributed to the marked increase in unmarried women attending the Local Health Authority Family Planning Clinic. Until 2 or 3 years ago only a few single women, about to be married, attended the Family Planning Clinic, but at the beginning of 1970 about one-third of new patients was unmarried and many of these did not anticipate marrying in the near future (Steiner, 1970).

Trends in female 'cases'

The number of female 'cases' increased from 133 in 1960 to 376 in 1968 and then fell to 329 in 1969. (In 1970 there were 349 female 'cases' out of a total of 1,228.) As the decade progressed, there was a marked increase in the proportion of females responsible for multiple 'cases', which reached a peak of 21 per cent. in 1968.

Residence

In about one-fifth of female 'cases' in each year the addresses given were outside the Aberdeen City boundary. Some of the women concerned worked in Aberdeen or their partners lived or worked in the City or they gave a history of sexual intercourse having occurred in Aberdeen. Also, a number of women moved about a good deal and were not consistently living in Aberdeen. It has been decided, therefore, to analyse data on all 'cases' together and to ignore the place of residence.

Referral

General practitioners and hospitals referred a similar number of 'cases' each year, but as the total number of 'cases' increased the proportional contribution of medical referrals almost halved in the decade (Table I). In 1969, these medical sources were jointly responsible for referral of slightly fewer 'cases' than were Adoption Agencies (15 per cent.) whose contribution had increased. Local Authorities requested serological tests on baby girls placed for adoption by them and they also referred a few girls who were 'on remand'. In all years, however, the majority of 'cases' (range 59 to 72 per cent. per year) arose from women attending of their own accord or on the advice of a partner or relative who was a possible source of infection.

Diagnosis

Before 1967, no venereal infection was diagnosed in over half the 'cases'. Fig. 2 shows that the number

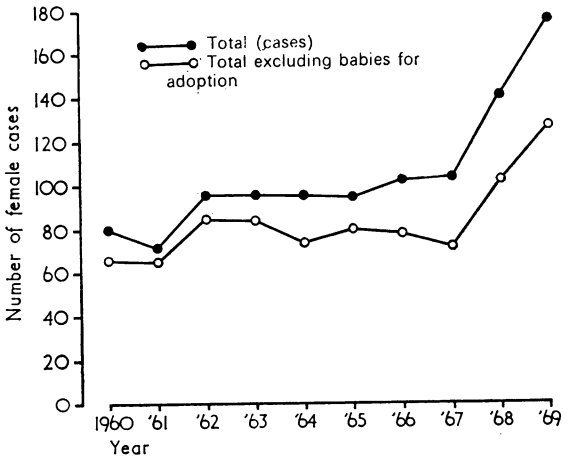

FIG. 2 *Non-venereal 'cases' in females, 1960–69. The number of babies for adoption is the difference between the two curves on the graph*

TABLE I *Female 'cases'. Mode of referral, percentage 'cases' per year*

Referred by	*Year*									
	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969
Hospital	15	13	12	8	9	10	7	4	7	7
General practitioners	13	19	10	13	15	13	7	12	7	7
Local authority (excluding adoptions)	—	4	—	1	1	1	2	2	4	3
Adoption agencies	11	5	6	7	13	8	13	13	10	15
Contact or self	61	59	72	71	62	68	71	69	72	68

of 'cases' of non-venereal conditions rose sharply and abruptly in 1968 and 1969. Babies for adoption are also included here, however, and in 1969 these accounted for 27 per cent. of 'cases' of non-venereal conditions.

All venereal infections in females reached a peak in 1968 (Fig. 3). Numerically, primary and secondary syphilis were unimportant and in five of the ten years only one such 'case' was reported annually. Some cases of late or latent syphilis occurred each year, usually referred, after serum testing, from hospital wards. In 1968, the number of infections with gonorrhoea was more than double that in previous years, but in 1969 the number had fallen again. Very few 'cases' of trichomonal vaginitis were diagnosed in the first 3 years

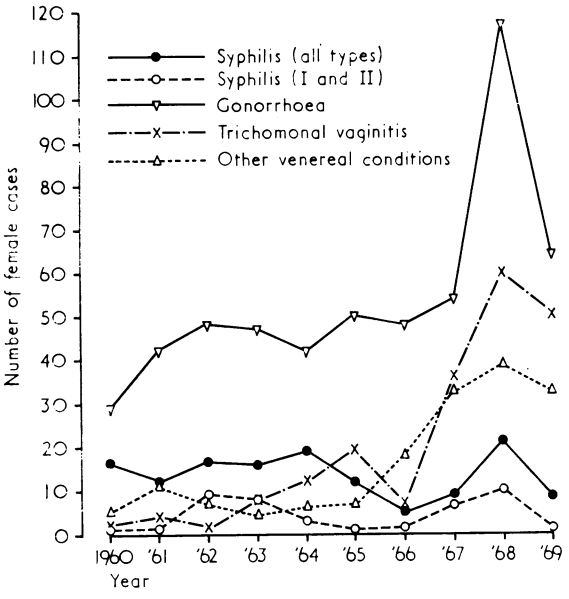

FIG. 3 *Diagnosis of venereal infections in females, 1960–69*

but, thereafter, the number rose to a peak in 1968; a marked fall in 1966 is unexplained. Other venereal conditions, predominantly genital warts and pediculosis pubis, have increased since 1965.

Age

Of the 1,603 females seen at the clinic in the 10 years, 273 were children under 15 and 133 were aged 45 and over when they first attended. As might be expected, there is a marked association between age and diagnosis (Table II). Only eight children had a venereal infection. Four of these girls had congenital syphilis diagnosed in the course of family follow-up studies. One girl suffered from trichomonal vaginitis and another had pubic lice. Two girls had gonorrhoea: a victim of sexual assault who had not yet reached the menarche, and a pre-school child who slept with her parents, both of whom were similarly infected. 82 per cent. of girls who attended the clinic were referred by Adoption Agencies and none had a venereal condition.

Women aged over 45 years provided the majority of 'cases' of late or latent syphilis. This is reflected in the fact that 42 per cent. of these older women had been referred by hospitals, and a further 14 per cent. by general practitioners. It was possible to establish that a number of these women had defaulted from treatment for syphilis in earlier years and had been untraced in the intervening period.

The 1,197 women aged 15 to 44 years who attended the clinic in the decade accounted for 1,686 'cases'.* The vast majority (79 per cent.) attended of their own accord or as contacts. No venereal condition was diagnosed in 44 per cent. of these 'cases'.

Women aged 15 to 24 years were responsible for the increased number of 'cases' dealt with in the 1960s. There were, of course, more women in this age group than in earlier years because of the high

*One woman who accounted for three 'cases' first attended as a girl aged 13 years 'on remand'.

TABLE II *Age at first attendance in any year, by diagnosis*

Diagnosis	*Age at first attendance (yrs)*			
	Under 15	15–44	45 +	*All ages*
Syphilis Primary and secondary	—	40	1	41
Other	4	37	54	95
Gonorrhoea	2	531	10	543
Trichomonal vaginitis	1	192	7	200
Other venereal condition	1	156	3	160
Non-venereal condition	265	729	58	1,052
Total 'cases'	273	1,685	133	2,091

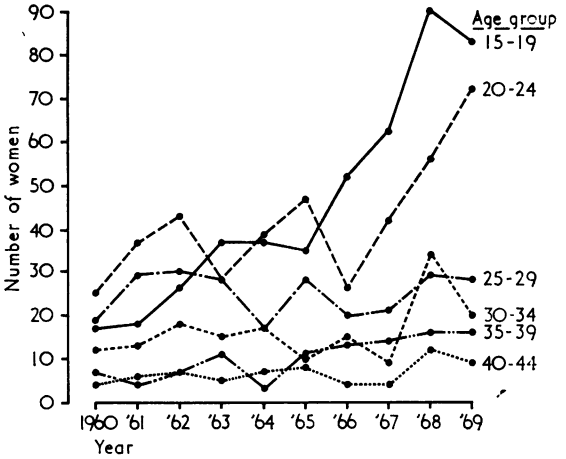

FIG. 4 *Numbers of women aged* 15 *to* 44 *years in* 5*-year age groups,* 1960–69

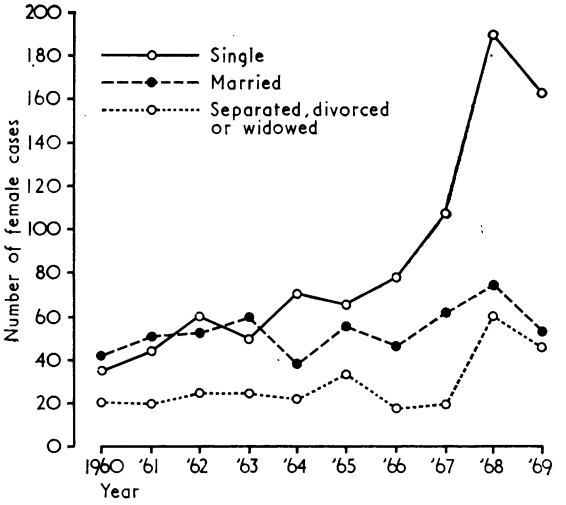

FIG. 5 *Cases in women aged* 15 *to* 44 *years, by marital status,* 1960–69

post-war birth rate. Fig. 4 shows that teenagers became the most numerous group for the first time in 1963, but their number did not increase again until 1966 when there was a steep rise to a peak in 1968. Women in their early twenties, otherwise the largest group, paralleled this rise but at a lower level. The number of women in all other age groups remained relatively steady throughout the decade.

In view of this trend to much younger patients, it is not surprising that the number of 'cases' attributed to single women increased with a particularly steep rise in 1967 and 1968 (Fig. 5). Figures for all marital states show a peak in 1968. Except for this year, the number of married women remained more or less unchanged throughout the decade, whereas that for separated and divorced women was also high in 1969; widows accounted for only fifteen cases in the 10 years.

The occupation of single women was stated with a few exceptions. Table III shows that all occupational groups contributed to the increase in V.D. clinic patients in the 1960s. At the beginning of the decade, however, 3·5 times as many manual as non-manual workers attended, whereas in 1969 there were nearly 1·5 times as many non-manual as manual workers. Schoolgirls and students, who were hardly ever seen at the clinic in the first 5 years, accounted for one-quarter of unmarried patients in 1969. A similar change has been noted in relation to illegitimate pregnancies. In each year a few 'unemployed' women gave a history of regular, frequent intercourse with different men, and for present purposes they have been called 'prostitutes'.

In view of the increase in young single women attending the clinic, it is not unexpected to find that more women who attended in the latter years had no children and fewer had three or more children. In 1960, 48 per cent. of women had no children compared with 58 per cent. in 1969; corresponding figures for women with three or more children were 24 and 16 per cent. respectively. In all years a few women who had had a sterilization operation attended, the proportion ranging from 3 per cent. in 1962 to 9 per cent. in 1966. Oral contraceptives were intro-

TABLE III *Occupation of single women aged* 15 *to* 44 *yrs, per year*

Occupation	*Year*									
	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969
Schoolgirl	—	—	1	2	—	1	3	4	3	8
Student	—	2	—	3	7	5	12	9	17	28
Non-manual	6	9	21	17	18	25	16	32	49	36
Manual	22	22	32	23	30	21	30	35	49	54
'Prostitute'	—	1	1	3	2	1	2	2	—	2
Not stated	—	5	1	1	4	6	3	5	4	9
Total women	28	39	56	49	61	59	66	87	122	137

duced by the Local Health Authority into Aberdeen in 1964, and in 1969 about 22 per cent. of the women at risk of pregnancy who attended the V.D. clinic were using oral contraceptives, and a further 3 per cent. were reported to have discontinued taking 'the pill'. Nearly 40 per cent. of pre-menopausal married women, who had not had a sterilization operation, had used 'the pill', a proportion similar to that estimated for booked, married Aberdeen women delivered in the Maternity Hospital (over 95 per cent. of all deliveries).

In order to study certain characteristics of women of childbearing age who use the V.D. clinic, the records for the 10 years, 1960–1969, will be analysed together because of small annual numbers.

Some characteristics of the women

Of the 1,197 women of childbearing age, 949 attended for one 'case' only in the 10 years, whereas one woman contributed twelve 'cases'.

Since women with multiple 'cases' at some point attended the clinic for the first time, details of the first attendance of all women will be described in order to ensure that all women are studied.

The marital status of the 1,197 women at the first attendance was as follows:

Single		615
Married	No extramarital coitus	297
	Extramarital coitus	68
	Coital history incomplete or not stated	56
Separated, divorced, or widowed		161

The women who admitted both marital and extramarital coitus had sometimes been separated intermittently or had taken other partners while their husband was working away from home; a few reported regular intercourse with the husband and another man. As these women form an intermediate group they will not be considered in detail.

The three major groups of women to be studied are those giving a history of coitus (1) premaritally (single); (2) with husband only (married); and (3) extramaritally (separated, divorced, or widowed). Certain characteristics of these groups are given in Table IV.

As the marital states represent a progression in the life cycle, it is to be expected that the single women would form the youngest group and the separated, divorced, and widowed women the oldest.

The sexual histories of the single women covered the widest range. A small number reported no coital experience and they were confirmed as 'virgo intacta' by clinical examination. Some of these girls said they had had genital contact while others were worried about the possible consequences of some incident, such as staying the night with an infected girl friend. Others, among the more educated, became alarmed after reading articles about venereal disease and wanted reassurance, although they had not been exposed to infection. For example a rash, eventually attributed to use of a deodorant spray, caused one girl to attend. Some girls gave a history of a single coitus, whereas others were 'prostitutes'. There were, however, proportionately twice as many 'prostitutes' among the separated, divorced, or widowed women

TABLE IV *Characteristics of women aged 15 to 44 yrs at first 'case', by marital status*

Characteristics		*Marital status (per cent.)*		
		Single	*Married No extramarital coitus*	*Separated, divorced, or widowed*
Aged under 25 yrs		90·2	40·4	28·6
*Sexual history**	No coitus	6·2	—	—
	One regular partner	36·2	100·0	39·7
	'Prostitute'	8·5	—	19·2
Diagnosis	Gonorrhoea	23·3	39·7	46·0
	Non-venereal condition	51·4	45·8	34·8
Childbearing history†	Previous pregnancies	18·6	90·4	93·7
	Pregnant‡	9·7	15·2	9·5
	Sterilization operation	0·3	9·6	12·6
Contraception	Condom mentioned‡	3·7	7·7	7·3
	On the 'pill' (1965–9)‡	6·8	18·4	16·7
Total no. of women		615	297	161

*No data on sixteen single and five separated, divorced, or widowed women
†No data on 28 single, four married, and two separated, divorced, or widowed women
‡Only patients at risk have been included

(19·2 per cent.), but a fairly similar proportion (over one-third) had a regular partner. All the married women had a regular partner, *i.e.* the husband, who, with a few exceptions, had a venereal infection.

Over half the single women had no venereal condition and the proportion of non-venereal conditions declined with occupational status, being highest in schoolgirls and lowest in 'prostitutes' who were most likely to have gonorrhoea (Table V). The greater promiscuity and unsettled way of life of the majority of the separated, divorced, or widowed women is reflected in the high proportion with a venereal infection.

TABLE V *Single women aged 15 to 44 yrs at first attendance, percentage with gonorrhoea or non-venereal condition, by occupational group*

Occupational group	*No. of women*	*Diagnosis (per cent.)*	
		Non-venereal condition	*Gonorrhoea*
Schoolgirl	21	76	10
Student	80	60	10
Non-manual	213	56	19
Manual	269	50	29
'Prostitute'	14	43	31

The childbearing and contraceptive history of the single women was very different from the fairly similar histories of the other two groups. The vast majority of married or formerly married women had had previous pregnancies. More separated, divorced, or widowed women had had a sterilization operation, such as tubal ligation or hysterectomy, which might be expected in view of their age and the fact that they had larger families. More married women, however, were pregnant. In general, married women are more continuously exposed to coitus and it is not surprising to find that more of them reported use of the condom or oral contraceptives. Regular use of the condom, however, was seldom mentioned. Sometimes a woman said that her partner used a condom 'once' or 'occasionally' or that one of several partners had used one.

Single women had had 3·8 per cent. of pregnancies terminated, as compared with 0·7 per cent. of pregnancies in the separated, divorced, or widowed women. No married woman reported a termination of pregnancy. The whereabouts of surviving children is shown in Table VI. Unmarried mothers cared for only 69 per cent. of their children, adoption being particularly frequent for the remainder. In the other two groups, a few children stated to be illegitimate had also been adopted. Most children not being looked after by their separated, divorced, or widowed mothers were 'in care'. Unfortunately the records are not sufficiently precise to identify all illegitimate children of the married or formerly married women.

TABLE VI *Care of surviving children by mother's marital status*

Care arrangements for children	*Marital status (per cent.)*		
	Single	*Married no extramarital coitus*	*Separated, divorced, or widowed*
Adopted	18·0	0·6	0·5
In care	10·0	0·2	4·3
With relatives	3·0	0·6	0·8
Kept by mother	69·0	98·6	94·4
No. of children	130	578	444
No. of mothers	99	238	149

Of the 248 women who accounted for more than one 'case' in the 10 years eighteen women, each with six or more 'cases', formed, in many respects, a fairly homogeneous group and are described below.

WOMEN WITH SIX OR MORE 'CASES'

Women with six or more 'cases', although forming only 1·5 per cent. of all women, contributed 8·8 per cent. of 'cases'; these included 18·2 per cent. of infections with primary and secondary syphilis, 13 per cent. of gonorrhoea, 19·9 per cent. of trichomonal vaginitis, and 5 per cent. of other venereal conditions.

Their ages ranged from 17 to 34 years when they first attended in the 1960s, but a few had earlier records and many were known to have attended other V.D. clinics during the period. At the initial visit, two were married and the rest were either single, separated, or divorced, but two of these subsequently married. Most of the eighteen women had further pregnancies during the period of their attendances and three had pregnancies terminated. There might have been several more pregnancies if six women had not used 'the pill' for fairly long periods, and one woman had a hysterectomy on account of fibroids. Sterilization failed in one woman, who produced another illegitimate child. The whereabouts of some of the children of these eighteen women is sometimes uncertain and as time went on they tended to 'forget' abortions or stillbirths; a continuous history would be necessary to clarify the matter in place of the independent records completed for each 'case' which are obviously prepared for clinical purposes and not for research purposes. The records indicate that the women had erratic employment histories in various manual jobs. Promiscuity was a feature of their lives and several had had every venereal infection. Foreign sailors were frequently mentioned as partners and several of the women kept returning to the Aberdeen Clinic after trips to other

ports in Scandinavia or Britain. Psychiatric disturbances, whether as a cause or effect of their way of life, were frequent. Five of the eighteen women had been in mental hospitals, one had committed suicide, and alcoholism and vicious behaviour were often mentioned.

Discussion

Venereal disease clinics deal with a wide range of patients from young babies to the aged victim of tabes dorsalis. The present analysis shows that the Aberdeen Clinic is no exception and it also shows trends similar to those reported from elsewhere in Britain (Ministry of Health, 1961; Department of Health and Social Security, 1970; Morton, 1970; Schofield and McNeil, 1970). Numbers of patients have increased, females proportionately more than males, more teenagers and the better educated are involved, and repeated attendances or infections are more common. Trends in venereal infections in both males and females in Aberdeen have paralleled those in Scotland, except for the atypical peak in syphilis and gonorrhoea in 1968 which is not readily explained.

There are no administrative barriers to attendance at the Aberdeen V.D. Clinic, which is open 5½ days and 3 evenings per week. The proportion of medical referrals halved in the 1960s and accounted for only one in seven women who attended the clinic in 1969. As reported from elsewhere in Britain, an increasing number of patients with no venereal condition attended the clinic, but the vast majority had run the risk of infection. There were a few, not sexually experienced, who needed reassurance because of their ignorance on the subject of venereal disease. An important factor, however, has been the large number of babies for adoption who are referred to the Aberdeen Clinic.

In Aberdeen, as elsewhere, infectious syphilis has declined, whereas conditions such as trichomonal vaginitis and genital warts are continuing to increase.

Gonorrhoea has increased throughout the world, and in Scotland the number of cases in women treated at V.D. clinics doubled in the 1960s (Schofield and McNeil, 1970), whereas in Aberdeen it remained fairly constant except for 1968.

Although V.D. clinic personnel probably play the major part in treating venereal diseases, we do not know how far other medical practitioners may be involved. Also, treatment given for some other condition (for example, penicillin for tonsillitis) may incidentally cure gonorrhoea. We know very little of the self-selection of patients (for example, which women may initially prefer to consult their own doctor) or of the practice of general practitioners in referring patients to the gynaecologist rather than to the venereologist. The present study suggests that single women are more likely to be sent to the V.D. clinic. Gynaecological patients are not screened routinely for venereal disease and gonorrhoea may thus be missed. A major problem in the control of venereal disease is the identification and treatment of asymptomatic females, and the follow-up of contacts for all infected patients is unlikely to be effective if patients are not seen at V.D. clinics.

It is generally agreed that the risk of venereal infection is less with a single consort. Since the majority of women aged over 25 are married, they are less likely to be exposed to casual sexual contacts. Separation and divorce, however, are increasing. Physical maturity is reached earlier and yet time spent in education has lengthened. It is not really surprising that coitus outside marriage, especially among the young and the better-educated, has increased in Western society in recent years. For example, the number of unmarried female students in Aberdeen has doubled in the past few years and the range of backgrounds from which students come has widened. Older teenagers are more affluent and have more freedom. There is greater mobility, as more people are studying or working away from home and holidays taken both at home and abroad are increasing. The whole idea of marriage and family life is being questioned. In such a period of social and moral upheaval, the concomitants of permissiveness (which inevitably embraces experimentation) are bound to appear.

The 'pill' is sometimes blamed for encouraging coitus outside marriage. Trends in premarital intercourse were already apparent, however, before oral contraceptives became available in Aberdeen. In any event there is plenty of evidence to show that coitus, particularly in the young, is often unpremeditated. Analysis shows that, at the present time in Aberdeen, oral contraceptives are, with a few exceptions, taken by women with a steady relationship, either inside or outside marriage; in the latter case, sometimes only after an unwanted pregnancy. Promiscuous women, many of whom cannot cope with the children they already have, can sometimes be encouraged to take oral contraceptives and thus to prevent the births of more unwanted children. This is important if Danish experience is relevant. Studies in Copenhagen suggest that the problem is self-perpetuating, since promiscuous mothers tend to be followed by promiscuous daughters (Ekström, 1970).

The condom played an insignificant part in the sexual histories of the women who attended the V.D. clinic during the 1960s. This is to be expected, as men interested in protecting themselves from

venereal disease are more likely to use the condom and thus help to limit the spread of infection.

A small number of sterilized women attended the Aberdeen V.D. Clinic each year in the decade under review, a time during which sterilization increased quite considerably. Many of the sterilized promiscuous women had illegitimate children and unsettled or broken marriages.

It is estimated that less than 1 per cent. of Aberdeen women of childbearing age (about 1·6 per cent. of teenagers) now attend the V.D. clinic annually and that about half of these have no venereal infection; thus the risks of coitus outside marriage may be thought worth taking, if indeed they are ever considered. Although such a small minority of women is affected, the matter cannot be considered lightly in view of the possible complications such as pelvic sepsis, sterility, prolonged illness, anxiety, long-term incapacity, and even death in certain cases of untreated disease.

Although knowledge of aetiology, accuracy of diagnosis, and efficacy of treatment play their part, major factors in controlling venereal infection lie largely outside medicine, in society itself. Control depends first on comprehensive sex education, so that no boy or girl runs risks through ignorance, and secondly on the development of responsible attitudes to sexual matters. In spite of the contemporary emphasis on sex, knowledge of venereal disease is often poor or confused. It is particularly important to give adequate publicity to the dangers of promiscuity, especially in those areas and among those sections of the community most at risk.

Sexual intercourse outside marriage is increasing and measures for the control of venereal disease are proving ineffective. In some areas there are fears of breakdown in the services of the overloaded V.D. clinics (*Sunday Times*, 1970; *Guardian*, 1970).

It was recently suggested (*Lancet*, 1970) that there is a need for a new look at the long-neglected venereal disease service in all its aspects. The attack must be made on several fronts simultaneously, education, identification of those exposed to risk, particularly of asymptomatic females, and treatment of the infected.

Summary and conclusions

The records of the females who attended the Aberdeen V.D. Clinic in the decade 1960–1969 have been analysed. There were 2·5 times more 'cases' (attendances for diagnosis or recurrent infection) in 1969 than in 1960. A relatively steep rise occurred after 1966, paralleling a similar increase in illegitimate pregnancies a few years earlier. A peak occurred in all venereal infections in 1968; non-venereal conditions continued to rise, however, indicating not only a greater demand for reassurance but also the use made of the clinic for serological tests of babies for adoption. In 1969 the Adoption Agencies accounted for 27 per cent. of the non-venereal 'cases' and referred about the same proportion of 'cases' as general practitioners and hospitals together. The proportion of medical referrals halved during the decade although the absolute number of such 'cases' referred remained fairly constant.

There was a marked change in the characteristics of women using the clinic; unmarried, teenage, non-manual workers formed an important group in the later years, whereas previously such girls were hardly ever seen.

In 1969, 22 per cent. of females at risk of pregnancy, who attended the clinic, were using oral contraceptives. The majority of single girls using 'the pill' had had a previous pregnancy and most of the remainder had a steady boy friend.

About one-quarter of patients who accounted for two 'cases' had gonorrhoea and concurrent trichomonal vaginitis. Women who contributed six or more 'cases' formed a fairly homogeneous group of promiscuous women whose histories referred to associations with foreign sailors, mental hospital admissions, suicidal tendencies, alcoholism, and vicious behaviour.

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La clinique vénéréologique d'Aberdeen, 1960-1969. Étude générale des consultantes

SOMMAIRE

On a analysé les observations des consultantes de la clinique vénéréologique d'Aberdeen pendant les dix années 1960–1969. En 1969, 2,5 fois plus de cas (consultations pour diagnostic ou pour infection récurrente)

qu'en 1960 furent enregistrés. Une augmentation relativement abrupte s'est manifestée après 1966, présentant un parallélisme avec une augmentation similaire des grossesses illégitimes dans les années juste précédentes. Un clocher fut observé pour toutes les affections vénériennes en 1968; les affections non vénériennes cependant continuèrent à augmenter, ceci non seulement parce qu'un plus grand nombre de sujets demandaient à être rassurés mais aussi parce que la Clinique eut la charge des tests sérologiques pratiqués à l'occasion de l'adoption de nouveaux nés. En 1969, les cas envoyés par les bureaux d'adoption figurent pour 27 pour cent des cas non vénériens, soit à peu près le même pourcentage que la somme des cas adressés par les praticiens généraux et les hôpitaux. La proportion des cas adressés par les médecins diminua de moitié pendant la décennie, quoique le nombre absolu des consultants restât à peu prés constant.

En 1969, 22 pour cent des femmes susceptibles d'être enceintes et qui consultèrent à la clinique utilisaient des contraceptifs oraux. La majorité des filles célibataires utilisant la 'pilule' avaient déjà été enceintes et la plupart des autres avaient un ami régulier.

Á peu près un quart des malades qui eurent à être enregistrées pour deux affections avaient en même temps une gonococcie et une vaginite à trichomonas. Les femmes venues six fois ou plus formaient un groupe bien homogène de femmes faciles, dans l'histoire desquelles on retrouvait la fréquentation des marins étrangers, des admissions dans des hôpitaux psychiatriques, des tentatives de suicide, l'alcoolisme et un comportement vicieux.